



hfm TOOLBOX

Brian Robertson

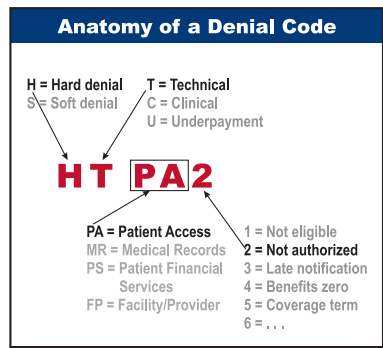
denials overturn analysis

Create a comprehensive denial code with only six characters by grouping elements from this matrix. Note that numbered elements vary in definition by their location in the matrix.

Denial Code Matrix					
Soft Denial			Hard Denial		
Clinical	Technical/Administrative	Underpayments	Clinical	Technical/Administrative	Underpayments
SC1	ST PA1	SU1	HC1	HT PA1	HU1
SC2	ST PA2	SU2	HC2	HT PA2	HU2
SC3	ST PA3	SU3	HC3	HT PA3	HU3
SC4	ST PA4	SU4	HC4	HT PA4	HU4
SC5	ST PA5	SU5	HC5	HT PA5	HU5
	ST PA6	SU6		HT PA6	HU6
	ST PA7	SU7		HT PA7	HU7
	ST MR1			HT MR1	
	ST MR2			HT MR2	
	ST MR3			HT MR3	
	ST MR4			HT MR4	
	ST MR5			HT MR5	
	ST FS1			HT FS1	
	ST FS2			HT FS2	
	ST FS3			HT FS3	
	ST FS4			HT FS4	
	ST FS5			HT FS5	
	ST FS6			HT FS6	
	ST FP1			HT FP1	
	ST FP2			HT FP2	

Denial Code Matrix Key

C Clinical	T Technical/Administrative	U Underpayments
C1 Medical necessity	PA Patient access	SU1 Underpayment/Payment not equal to claim
C2 Noncovered service	PA1 Not eligible	SU2 Underpayment/Payment not equal to case rate
C3 Util/Level of care	PA2 Not authorized	SU3 Stop loss not paid - Payer paid routine
C4 Nonemergent	PA3 Late notification	SU4 Underpayment/Paid wrong DRG
	PA4 Benefits zero	SU5 Underpayment/Correct % of charges not paid
	PA5 Coverage term	SU6 Underpayment/Invalid fee schedule
	PA6 COB (Other insurance prime)	SU7 Underpayment/Incorrect per diem paid
	PA7 COB (Auto insurance coverage)	
	MR Medical records	
	MR1 Service not paid	
	MR2 Invalid recipient age	
	MR3 Invalid Gender	
	MR4 Diagnosis not covered	
	FS Patient financial services	
	FS1 Duplicate claim/service	
	FS2 Timely filing limit	
	FS3 Lack of information	
	FS4 Payment adjustment to UCR	
	FP Facility/Provider	
	FP1 Invalid NO provider number	
	FP2 Provider # license not on file	



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TOOLS TO SHARE

If you have developed a useful tool that you'd like to share, please contact Carole Bolster, senior editor, at cbolster@hfma.org.

The first rule of effective denials management is to thoroughly understand your denials portfolio. Such an understanding is impossible without overturn analysis based on the details of all three denial states: pending, won, and lost. Only with a complete data set can you obtain the win/loss metrics that present an accurate assessment of your denials status:

- > What is my win/loss experience of denials (by payer, functional area, reason code)?
- > Where am I successfully overturning denials (by payer, functional area, reason code)?
- > Where am I unsuccessfully overturning denials (by payer, functional area, reason code)?

Knowing your true situation, you can develop a macro strategy for getting to the root causes of major denial types and thus forestalling future denials, and a micro strategy for highlighting and overturning individual denials that have common success potential. You have the best of both worlds. But only universal, claim-level granularity can provide the total solution. And there, as Shakespeare said, is the rub.

The challenge in achieving granularity is to overcome the tendency of internal departments and external payers to define claims in different and conflicting ways. The answer is codification.

Using an alphanumeric code that contains the essential characteristics of a denial makes that denial available for overturn analysis and for work list generation.

Once you have a denials code that suits your organization, it should be adopted by all departments and applied to all denials, including write-offs. Interim denial transactions should not only be recorded, but also codified, using a mapping matrix of denial code components. Then you can use crosswalking to apply complementary coding to subsequent transactional activity from payers (typically presented in the form of electronic or paper remittance advices). The coding commonality enables you to compare payer activity with the original recorded interim denial, thus providing a complete denials data set.

Using denial overturn analysis, you can mine your denials data set to spot trends that lead to internal process improvements, reduce the likelihood of future denials, and create work lists that point collection and billing staff to the most promising candidates for overturn. ●

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